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Learning objectives for this issue:
1. Describe how rating scales are used in diagnostic assessment of children **2.** Explain the key features of some of the most common rating scales for children and adolescents **3.** Put rating scales into use in your practice
4. Understand some of the current findings in the literature regarding psychiatric treatment

The Use of Rating Scales in Diagnostic Assessment of Children

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Dr. Lee has disclosed that she has no relevant relationships or financial interests in any commercial companies pertaining to this educational activity.

Rating scales have been gaining favor in diagnostic assessment of children with psychiatric and/or neurodevelopmental disorders. Many children have trouble talking directly about their behavior, and rating scales can often help clinicians fill in the blanks. While they have their benefits, misuse or overreliance on rating scales can interfere with the assessment process and lead to misdiagnoses, inappropriate interventions, and poor outcomes.

Furthermore, they don't replace the old-fashioned diagnostic interview, which brings with it alliance-building, subtle reassurance, and cultivation of the doctor-patient relationship. And don't forget that as part of the assessment, you also want to get the perspective of the child's parents because they are typically key players in facilitating change.

So how can rating scales be most useful to psychiatrists and patients? Which rating scales should you use? In fact, so many questionnaires exist that clinicians may find themselves in a conundrum over which scales to incorporate into their assessments, as well as what to make of those they choose. Let's look at some of the facts you need to know about scales, as well as the pros and cons for using them when evaluating children.

The Facts About Rating Scales

First, it is important to understand how a rating scale is created. Typically, a group of experts develop a number of potential items that fit the intended construct. For example, if the rating scale is to assess behavioral problems, it might include the item: "My child hits others." Next, the items are analyzed statistically, using techniques such as a factor analysis, to see how the test items naturally cluster together (eg, what items represent "aggression"). The scale developers then do pilot studies to weed out "bad" items and confirm the "good" ones.

When the final version of the rating scale is complete, it is standardized. A sample of people who reflect the U.S. population completes the questionnaire, and normative scores are produced to determine appropriate cut-off scores for what is deemed a clinically significant behavior. Basically, this answers the question, "How often does an average individual engage in this behavior," generally broken down by age and gender.

In addition to standardization, test developers also need to measure the psychometric properties of a given scale. Good reliability (how consistent the scale is) and validity (does the scale measure what it's supposed to) are essential to clinical use of a rating scale. You will usually find information on test development and psychometric properties in the manuals that accompany rating scales, and you can also obtain this information from the medical literature or the publisher.

While you may be tempted to ignore these chapters and jump into administration and interpretation, it is important that you look at these elements to ensure the scale is actually worth giving to your patients. Next it is important to understand the structure and limits of each scale. Some scales such as the Behavior Assessment System for Children, Second Edition (BASC-2), Conners Comprehensive Behavior Rating Scales (CBRS), and Personality Inventory for Children, Second Edition

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The Use of Rating Scales in Diagnostic Assessment of Children

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(PIC-2) are called multidimensional or omnibus. This type of scale evaluates the individual for several dimensions of behavior or temperament and can screen for several diagnoses. Other scales are more targeted and intended for refining specific diagnoses, such as the Conners Third Edition, known as Conners 3 (for ADHD), or the Gilliam Autism Rating Scale (GARS) (for measuring the severity of autism).

Some rating scales can be used as screens for possible psychopathology or atypical development. Others are designed to measure response to interventions over time, and are meant to be given repeatedly. You can use rating scales to confirm diagnoses, but only when you include other assessment methods such as a clinical interview and direct observation of the child.

You also want to consider the pragmatics of the scales when choosing which ones to use in your practice.

Scales vary in the number of questions, the sophistication of the language, and the way the data is recorded and scored (entirely by hand, by computer after input from handwritten forms, or by input into a computer directly by the patient). It is important to choose a scale that a patient can realistically complete in the time available and that staff can score within a reasonable amount of time.

Let's be honest; these scales are not cheap. So when you consider the use of a new scale, think about how to conserve its use as well. For example, it will be expensive to mail commercial scale forms to patients prior to an intake appointment if the no-show rate is high. In that situation, it might be better to ask the families to come to their appointment early and fill out the questionnaire in the waiting room.

The Benefits of Using Scales

Rating scales offer numerous benefits as an aid for clinical assessment. They are easy to administer and create minimal time and burden for the clinician. Scoring is also easy, particularly if they use a computer scoring program. You can gather information on how a child behaves across different settings (eg, home vs school) in a cost efficient manner without having to interview informants directly. This way, discrepant scores can inform you that specific environments or people may be triggering maladaptive behaviors. With multidimensional questionnaires, you get a lot of "bang for the buck," since the questions cover a broad domain and can pick up areas of potential psychopathology that you may have not addressed in the clinical intake. This is particularly true given the comorbidity that exists among psychiatric and neurodevelopmental conditions. You can scan specific items and then follow up with the rater on a particular area of concern (eg, hallucinations or self-esteem).

Psychometric properties of rating scales have improved in recent years, and many are now developed using national samples through empirically valid methods. Assuming that scores adequately depict how a child is functioning, composite scores (typically T-scores) are presented in a continuous rather than dichotomous fashion. Line graphs provide a visual representation of the scores and can be helpful in revealing the severity of each domain.

Although clinicians often use a cutoff score to help determine eligibility in a diagnostic category, examining the specific scores can be useful in identifying at-risk behaviors. You can administer rating scales repeatedly across time to provide longitudinal data for a child. This can be particularly useful to track the effectiveness of specific interventions, and can be a great visual aid for a concerned parent. Rating scales meet the IDEA criteria of quantifiable data, and should therefore hold weight in determining a patient's eligibility for an individual education plan (see *CCPR,* October 2011, for more detail on this).

What is a T-Score?
T-scores are standardized scores. A score of 50 represents the mean. A difference of 10 from the mean indicates a difference of one standard deviation. Thus, a score of 60 is one standard deviation above the mean, while a score of 30 is two standard deviations below the mean.

Source: University of Chicago Library

Rating scales can objectify symptom severity for third-party payers, as well as show patients and their parents evidence of improvement (or lack thereof). Norms and standardization make for a built-in way to answer the question, "But doesn't every child do this?" Most important, you can use rating scales when the treatment isn't working, by helping you go back to the beginning and ask, "What did I miss?"

The Limitations of Scales

Despite the numerous benefits of incorporating rating scales into diagnostic assessment, there are pitfalls you should be aware of. First of all, it is far too tempting to use the questionnaires for more than they were intended. You

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Selected Diagnostic and Rating Scales

Scale Name	Tracks to DSM-IV Diagnosis	Age Range	Approximate Cost Per Patient	Available Languages	Patient Input Method	Reporter	Scoring Method	Time Required (in minutes)	Specialized Training Required	Screen and/or Intervention	Assessment or Diagnosis	Where to Obtain
Beck Youth Inventories Second Edition (BYI-II)	Yes	7 to 18	$7.32	E	P	S	P	5 to 25	B	S, I	General	Commercial Publishers
Behavior Assessment System for Children, Second Edition (BASC-2)	No	2 to 21	$7+	E, S	P, O	S, T, P, Tr	C, O	10 to 30	B	S	General	Commercial Publishers
Brief Infant Toddler Social Emotional Assessment (BITSEA)	No	Preschool (12 to 35 months)	$4	E, S	P	P, Tr	P	7 to 10	B	S, I	Preschool	Commercial Publishers
Brown Attention-Deficit Disorder Scales (BrownADDScales)	Yes	3 to adult	$9	E	P	S, P, Tr	P, C	10 to 20	B	S	ADD	Commercial Publishers
Child Depression Inventory 2 (CDI 2)	Yes	7 to 17	$10.68	E	P	S, P, Tr	P	5 to 20	A	S, I	Depression	Commercial Publishers
Children's Aggression Scale (CAS)	No	5 to 18	$9.92	E	P	P, Tr	P	10 to 15	B	S	Aggression	www.parinc.com
Children's Nonverbal Learning Disabilities Scale (C-NLD)	No	5 to 18	Free	E	P	P	P	5 to 10	A	S	Non-verbal learning disabilities	http://bit.ly/JTEROM
Childrens PTSD Inventory (CPTSDI)	Yes	6 to 18	$2.72	E, S, F	P	T	P	5 to 20	C	S	PTSD	Commercial Publishers
Conners Comprehensive Behavior Rating Scales (Conners CBRS)	Yes	6 to 18	$6	E, S	P, C	S, P, Tr	P, C	20	B	S	General	Commercial Publishers
Conners Third Edition (Conners 3)	Yes	6 to 18	$6	E, S	P, C	S, P, Tr	P, C	5 to 20	B	S	ADHD	Commercial Publishers
Child Development Inventory (CDI)	No	1 to 6	$3	E	P	S	P	30 to 50	A	S	Preschool	Commercial Publishers
Devereux Scales of Mental Disorders (DSMD)	Yes	5 to 18	$4.25	E	P	P, Tr	P	15	B	S	General	Commercial Publishers
Eyberg Child Behavior Inventory (ECBI) and Sutter-Eyberg Student Behavior Inventory (revised) (SESBI-R)	No	2 to 16	$3.96	E	P	P (ECBI), Tr (SESBI-R)	P	5 to 10	B	S	Disruptive behavior	www.parinc.com
Gilliam Autism Rating Scale Second Edition (GARS-2)	Yes	3 to 22	$1.25	E	P	T, P, Tr	P	5 to 10	B	S	Autism	Commercial Publishers
Infant Toddler Social Emotional Assessment (ITSEA)	No	Preschool (12 to 36 months)	$4	E, S	P	P, Tr	P, C	25 to 30	A	S, I	Preschool	Commercial Publishers
Multidimensional Anxiety Scale Children (MASC)	Yes	8 to 19	$4.80	E	P	S	P	5 to 15	B	S, I	Anxiety	Commercial Publishers
Sleep Disorders Inventory for Students (SDIS)	Yes	2 to 18	$1.65	E, S	P	T	C	10	A	S, I	Sleep disorders	Commercial Publishers
Suicide Probability Scale (SPS)	No	14 and up	$3.96	E	P	S	P, C	5 to 10	B	S	Suicide risk	Commercial Publishers
Young Mania Rating Scale (YMRS)	Yes	5 to 17	Free	E	P	T, P	P	15 to 30	B	S, I	Mania	http://bit.ly/N0MMhm

Key

Available Language: E=English; S=Spanish; F=Canadian French; **Patient Input Method:** P=paper and pencil; C=computer data input; O=Online.
Time Required: average approximate time to take the test; **Specialized Training:** A=no specific training required; B=college degree or other special training; C=advanced degree or test specific training
Reporter: S=self report; T=therapist; P=parent; Tr=teacher

Commercial Publishers: Pearson (www.pearsonassessments.com); Western Pscyhological Services (www.wpspublish.com), and Multi-Health Services (www.MHS.com)

Q&A With the Expert

Expert Interview

Using Rating Scales in Your Practice

Brent Collett, PhD

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Dr. Collett has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

CCPR: Dr. Collett, you have written many reviews of rating scales. How are rating scales useful for clinicians?
Dr. Collett: For one, clinicians can use rating scales to make an initial assessment and document that a child really has a problem relative to other kids his or her age. For instance, it is important to know that the level of hyperactivity that a preschooler in your office is showing is different than what we would expect preschoolers to show. It is really striking how often a perfectly normal preschooler refuses, and argues, and demonstrates a lot of behaviors that could be considered part of the pathology of ADHD. Rating scales provide a big normative sample that you can use for comparison, allowing clinicians to say more definitively that a behavior is different than what you would expect from another kid the same age.
CCPR: So a rating scale can answer the question, "Is this normal compared to other kids of this age group or developmental stage?"
Dr. Collett: A rating scale gives you data to back up your clinical judgment. It also gives you an efficient system to gather data from multiple people, such as teachers, the parents, and the children themselves. With a questionnaire, they all respond to the same questions. It gives you information from different people's perspectives and reports behavior across different settings, and it is usually more efficient to send out a rating scale rather than make phone calls to different people to get that information.
CCPR: How do you think rating scales should be used? Should clinicians ask all new patients and their families to fill them out? Or should they use ratings scales before diagnosis, after diagnosis, and after treatment to track progress?
Dr. Collett: There are two categories of rating scales: broad- and narrow-band. Broad-band rating scales, such as the Child Behavior Checklist and BASC [Behavior Assessment System for Children], can help you assess a wide range of presenting problems at the outset. It makes sense to get comfortable using one of those scales to get a thorough patient evaluation. Narrow-band scales are used to assess more specific problems. For instance, clinicians can use MASC (Multidimensional Anxiety Scale Children) to assess anxiety or some of the Conners' Rating Scale short forms that are tailored to assess ADHD. Clinicians can use these scales for a more refined assessment or even for repeated assessment—before and after you started treatment. The scales can help a psychiatrist monitor the effect of a medication or some other treatment.

It is important not to make a diagnosis just because a child scores high on a rating scale. Of course, you want to consider how the score compares to your clinical judgement.
Brent Collett, PhD

CCPR: What factors should a clinician consider in choosing a rating scale?
Dr. Collett: You want to think through what the function is going to be for this test. Is it going to be an initial part of your diagnostic assessment or is it going to be a part of your ongoing monitoring? If it is part of the initial assessment, it is okay to use a slightly longer rating scale because respondents will only fill it out once. You really want it to have good coverage and you want it to distinguish clinical from nonclinical groups. If you are choosing a scale for ongoing assessment, length matters a lot; you don't want parents to have to sit and fill out a 200-item scale every time they come to see you. You want them to be able to do a more focused assessment and you want it to be sensitive to treatment gains.
CCPR: Sometimes you can have tests that are sensitive to treatment but not necessarily good diagnostic instruments. How does this apply to ratings scales?
Dr. Collett: Again, you need to consider what you are using the scale for. Obviously, if you are using the scale to justify your initial diagnosis you want really good sensitivity in terms of distinguishing clinical groups from nonclinical groups. If you are using a scale to document treatment effect, then you really want to know that it has sensitivity to detect a change.
CCPR: The Individuals with Disabilities Education Act (IDEA) requires quantifiable testing for diagnosing a condition that impairs education. Do rating scales count when it comes to producing quantifiable results?
Dr. Collett: They do. Rating scale results would be a very reasonable source of data for that kind of decision. In fact, that is one of the tools that school systems use internally when they are doing their eligibility evaluations.
CCPR: How do we know that rating scales are accurate?
Dr. Collett: In general, the manual for a good rating scale provides information about its reliability, such as how consistent the scores are over time and across different raters. However, sometimes rating scales get disseminated without having a lot of that data. The next step in developing a scale is to collect validation data showing that kids who have a diagnosis differ in some predictable way from kids who don't have a diagnosis. Finding validation data sometimes takes more digging, and is usually harder for test developers to establish. Some tests might actually not have as much validation data as you would want.

CCPR: Is that worth looking for?
Dr. Collett: Definitely. You may need to do a literature review or actually look at a manual for the scale that you are going to use. Then the other kind of validity data would be sensitivity—for example, knowing that it is sensitive to a treatment effect or sensitive to other variations over time. You want to know that if your treatment produced a change in a child that you should see a corresponding change in the rating scale.
CCPR: What are some particular problems using rating scales with children and adolescents?
Dr. Collett: Parents will often say, "Well, I could make my child 'look' however I wanted to on this rating scale. If I really wanted him to have ADHD I could endorse all of the twos, and if I didn't, I could endorse all of the zeroes," or a teacher could do the same if they have their own agenda.
CCPR: So how is the best way to manage that?
Dr. Collett: It is absolutely true that people could skew findings on a rating scale in one way or another, and it is worth thinking about some of the variables that might affect responding. For example, sometimes a parent's or teacher's level of distress or concern can influence ratings. So you want to have multiple different reporters, then look at the differences among them, and think through how this might all make sense. It is also important not to make a diagnosis just because a child scores high on a rating scale. Of course, you want to consider how the score compares to your clinical judgment about the patient and what you are seeing in the office.
CCPR: Do rating scales present different problems for young children than they do for older kids?
Dr. Collett: A child under age five or six really cannot provide a great self-report on a rating scale. You will need to rely mostly on reports from the parents and teachers for kids this young.
CCPR: When we are dealing with teenagers, do you think that the patient's self-report should have more weight than the other individuals' reports?
Dr. Collett: Not necessarily. Kids tend to underreport externalizing (behavior) problems overall. So if you are asking teens about the deviant things that they do, they tend overall to report less than their parents and their teachers do, which isn't so surprising, really. On the flip side, parents and teachers tend to underreport internalizing problems and subjective distress like anxiety or depression. Which one has more impact on the treatment depends on some of the other presenting facts that you know about the teen.
CCPR: Do you think that there are any inherent risks in using rating scales?
Dr. Collett: One risk is assuming that just because something comes out of a scoring program or algorithm that it is "the truth." That is dangerous because it should be viewed as just one source of data, weighed against all of the other data that you have about a child and your clinical judgments and impressions. All of those things don't go out the window just because you have this one instrument.
CCPR: How would you recommend reconciling clinical judgment with a rating scale?
Dr. Collett: In private practice a psychiatrist can keep the mental status exam and their own clinical impressions in the room and then compare that to what they get from scale and think about what the differences are. Keep in mind that a child's behavior can vary in different settings. In my work with very young children under five years old, they often are fine when they come to my office. However, I do believe their parents' reports of tantrums at home and other behavior problems. They just don't show up in our setting because it is novel and the children are usually getting a fair amount of attention. It is not that the rating scales are right and I'm wrong; it is just that behavior varies across different settings. It is important to use all of the data that you get.
CCPR: How should a clinician go about choosing a rating scale?
Dr. Collett: Reviewing the literature is a good start. See what has been reported in the peer-reviewed research and look for a rating scale that suits your needs. So if you are working mostly with inner city kids in Chicago, you want to be sure that the rating scale reflects that kind of population, the "normative group" as it is called. The group that the scale was developed with should reflect the population that you are working with.
CCPR: So it should be as close as possible to your own patient group?
Dr. Collett: Yes, and that can be hard sometimes for people in unique settings. In general it should be close or you should at least know how it differs from the population that you work with, which you can find out from the test manual or from published research.
CCPR: In practical terms, some of the scales are free and others are decidedly not. Some require complicated scoring and some do not. Is there an easy way to sort those out?
Dr. Collett: There are some good free scales. For example, the Vanderbilt scales for ADHD have a really good set of evidence behind them. They have norms and good data on reliability and validity. There are other scales you can find free online that still have pretty good data. Sometimes it takes a little more investigating to be sure that the one you choose does have that kind of data. Published (ie, those you have to pay for) instruments usually have at least reasonably good norms and evidence of reliability. They won't always have as much validity data as we would like, but a clinician who uses a published scale might not have to dig as they would for some of the free scales to get that information.
CCPR: Thank you, Dr. Collett.

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Research Updates IN PSYCHIATRY

SUBSTANCE ABUSE

Is Frequency a Good Indicator of Problem Drinking in Adolescents?

The American Academy of Pediatrics recommends healthcare providers routinely screen all adolescents for alcohol use and related problems. But how can clinicians easily and effectively determine if adolescent patients have a problem with alcohol? A recent population-based study concluded that a brief screen on drinking frequency efficiently identifies youth with alcohol-related problems.

The researchers looked at data from more than 166,000 youth ages 12 to 18 who participated in the annual National Survey on Drug Use and Health from 2000 to 2007. Researchers considered three factors to measure alcohol consumption: the frequency of alcohol use in the past year, the quantity consumed on each occasion, and the frequency of heavy drinking episodes in the past month. They looked at whether these three measures, based on age and gender, correlated with either of two outcomes: a diagnosis of alcohol dependence (the more severe outcome) or any DSM-IV alcohol use disorder (AUD) symptoms (the less severe outcome). More than either the quantity consumed per episode or the frequency of heavy drinking, the frequency of *any* drinking had higher sensitivity and specificity in identifying both alcohol dependence and AUD symptoms.

Prevalence of the two outcomes increased with age, researchers said. Adolescents having any AUD symptom ranged from 1.4% at age 12 to 29.2% at age 18. The most common symptom was tolerance. Those with alcohol dependence ranged from 0.2% at age 12 to 5.3% at age 18.

Clinicians can use a range of age-specific cut-offs to help determine if patients have an alcohol problem, or alcohol dependence, researchers said. In short, one occasion of drinking in the past year for youths aged 12 to 15 may indicate problem drinking; in 16 to 17 year olds, more than six days of drinking a year (once every other month) may indicate a problem; for 18 year olds, more than 12 days of drinking a year (monthly) may indicate a problem. For alcohol dependence, cut offs were: six or more days of drinking per year among 12 to 15 year olds, 12 or more days of drinking per year among 16 year olds; 24 days of drinking per year among 17 year olds; and 52 days of drinking per year among 18 year olds (Chung T et al, *Pediatrics* 2012;128(1):e180–e192).

CCPR's Take: Because alcohol is the most widespread and available intoxicant for adolescents, we need to ask about alcohol use in a meaningful manner. This study gives some concrete guidelines to help clinicians know when kids are deviating from normal adolescent behavior.

ADHD

Study Shows Link Between TFA Intake and ADHD

A study by Korean researchers shows that female adolescents with ADHD have a significantly higher intake of trans fatty acids (TFA) than those without the disorder. The researchers concluded that the finding suggests that high intake of TFAs may act as a potential pathophysiology in the development of ADHD.

The researchers from several academic medical centers in Seoul conducted the study to look for a relationship between ADHD and the intake of TFAs—unsaturated fatty acids containing trans double bonds between carbon atoms that are typically produced during industrial hydrogenation of vegetable oils—in female adolescents. A well known risk factor for cardiovascular diseases, several studies have suggested that consumption of TFAs may negatively affect brain functioning, the researchers noted. However, few studies have examined the influence of TFAs on ADHD.

The study sample consisted of 485 students attending their first or second year at a girls' high school in Seoul. Based on scores on the short form Conners-Wells Adolescent Self-Report Scale (CASS), subjects were categorized into either an ADHD group (21 girls) or a non-ADHD group (464 girls). Researchers used the self-reported Food-Frequency Questionnaire (FFQ) to assess food consumption and nutrient intake for the preceding 12 months. Using an additional survey, they also assessed the types of oils used and the intake of vitamins and mineral supplements. To confirm the independent association between ADHD and TFAs, the researchers performed multiple logistic regression analyses after adjusting for age, body mass index, socioeconomic status, current smoking, alcohol consumption, regular exercise, and intakes of energy and other nutrients as independent variables. In multiple logistic regression analyses as, TFA intake was an independent factor associated with ADHD, the researchers found.

The researchers noted several limitations to their study, including the fact it relied on self-reported measures, which are vulnerable to over-reporting and self-presentation biases. Also, researchers did not conduct fatty acids analysis in plasma or red blood cell membrane, which was known to be a standard for testing levels of TFAs in the body. The only screening tool for ADHD was a self-reported questionnaire. Finally, it is difficult to identify mechanisms underlying relationships between TFA intake and ADHD using a cross-sectional study design (Kim JH et al, *Acta Paediatr,* accepted article, prior to publication).

CCPR's Take: While the Korean study suggests that female adolescents with ADHD have significantly higher TFA intake than those without ADHD, the researchers themselves say further prospective studies are necessary to determine the relationship between the two and to identify its related factors.

CME Post-Test

CME Notice: The test below is intended to be for **practice only.** All subscribers must take their tests online at www.thecarlatchildreport.com. If you cannot take your test online, please call 866-348-9279 or email info@thecarlatreport.com.

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. The process of standardizing a rating scale basically answers the question: How often does an average individual engage in this behavior? (Learning Objective #1)

   [ ] a. True
   [ ] b. False

2. Among these scales for general assessment, which is the least expensive to use (LO #2)?

   [ ] a. Behavior Assessment System for Children, Second Edition (BASC-2)
   [ ] b. Beck Youth Inventories Second Edition (BYI-II)
   [ ] c. Devereux Scales of Mental Disorders (DSMD)
   [ ] d. Connors Comprehensive Behavior Rating Scales (Connors CBRS)

3. According to Brent Collett, PhD, children are really not capable of providing a good self-report when they are under what age (LO #3)?

   [ ] a. Age 11 or 12
   [ ] b. Age 8 or 9
   [ ] c. Age 5 or 6
   [ ] d. Age 2 or 3

4. The combined result of the annual National Survey on Drug Use and Health from 2000 to 2007 found what percentage of 18 year olds had any alcohol use disorder (LO #4)?

   [ ] a. 1.4%
   [ ] b. 12%
   [ ] c. 29.2%
   [ ] d. 45.6%

5. A recent study by Korean researchers shows that female adolescents with ADHD have a significantly lower intake of trans fatty acids (TFA) than those without the disorder (LO #4).

   [ ] a. True
   [ ] b. False

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The Use of Rating Scales in Diagnostic Assessment of Children

Continued from page 2

don't want to use the rating scales as the primary basis for diagnosing a condition and skimp on other important parts of the assessment process. This is particularly hard to resist when the questionnaire has categories that already correspond to specific diagnoses from the DSM-IV-TR. Unfortunately, this can be an issue if the time allotted for each patient is brief.

Another negative aspect of rating scales is that the validity of the instrument is limited by the rater's objectivity in item response. For example, some parents who are overwhelmed by their child's misbehavior may mark "almost always" for virtually every negative behavior, which then results in a T-score well over 70 across all domains. This bias can be difficult

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to interpret, particularly if responses from other raters are dissimilar. Assessment of behavioral change can also be difficult over the short-term, particularly as negative behaviors might remain clinically elevated for some time even if improvement is taking place.

While rating scales are useful in identifying the frequency and severity of problem behaviors, they do not reveal how particular behaviors affect a child's daily functioning. Therefore, follow-up interviews, inference, and other assessment tools are necessary to determine which problem behaviors should be the target of intervention.

CCPR'S VERDICT: Behavior rating scales can be important tools for screening for the presence of maladaptive behaviors in children across settings. They offer ease and convenience in the assessment process and can incorporate a whole host of behaviors. Rating scales have improved over the years in validity and reliability, as well as clinical utility. However, they should never be used in isolation or interpreted by lay people. The use of these scales, in conjunction with a more in-depth clinical interview and comprehensive battery of tests, can lead to accurate diagnoses and ultimately, effective interventions.

Next Time in *The Carlat Child Psychiatry Report:* Transitional Age Youth, with an overview of "failure to launch" and tips for empowering your young patients around their diseases.

This Issue's Focus:
Rating Scales

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